Supreme Court, U.S.
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No. 97-218

In the Supreme Court of the United States

OCTOBER TERM, 1997

STEVEN B. LARSEN, MARYLAND INSURANCE COMMISSIONER, PETITIONER

v.

AMERICAN MEDICAL SECURITY, INC., ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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QUESTION PRESENTED

Whether Section 514 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, precludes a State from specifying minimum coverage "attachment points," below which insurance policies drafted in the form of "stop-loss" or "catastrophic loss" insurance may be sold to employee benefit plans only if they comply with the State's requirements for conventional group health insurance policies.

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This brief is submitted in response to the Court's order inviting the Solicitor General to file a brief expressing the views of the United States.

OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-15a) is reported at 111 F.3d 358. The opinion of the district court (Pet. App. 19a-34a) is reported at 915 F. Supp. 740. The district court's judgment order (Pet. App. 35a-37a) is unreported.

JURISDICTION

The judgment of the court of appeals was entered on April 11, 1997. A petition for rehearing was denied on

May 6, 1997. Pet. App. 16a-18a. The petition for a writ of certiorari was filed on August 4, 1997. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. Under the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1001 *et seq.*, the term "employee benefit plan" includes "any plan, fund, or program" maintained by an employer to provide "medical, surgical, or hospital care or benefits" to its participants or their beneficiaries, "through the purchase of insurance or otherwise." 29 U.S.C. 1002(1) & (3). Although ERISA generally preempts "any and all State laws insofar as they * * * relate to any employee benefit plan," 29 U.S.C. 1144(a), a saving clause provides that ERISA shall not be construed "to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). A benefit plan itself may not, however, be "deemed to be an insurance company or other insurer * * * or to be engaged in the business of insurance" for purposes of any state law "purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. 1144(b)(2)(B).

Some employee plans purchase group insurance that provides health benefits directly to plan participants. Others pay covered health care expenses directly from the assets of the employer, or from a trust funded by employer (and sometimes employee) contributions. Even such "self-funded" plans, however, often purchase insurance to protect themselves against the possibility of unexpectedly high claims. Such "stop-loss," "excess loss," or "catastrophic loss" policies reimburse the plan for benefit

obligations in excess of certain "attachment points" —typically a "specific" attachment point, expressed as a dollar amount per participant per period, and an "aggregate" attachment point, representing a multiple (such as 110% or 115%) of the total claims expected during the period. Stop-loss insurance differs contractually from group health insurance in that the plan (or its employer sponsor) remains directly liable to participants for the payment of promised benefits, while the insurer assumes no direct liability to plan participants.

2. Petitioner regulates the insurance business in the State of Maryland. At least since the 1993 passage of the Maryland Health Insurance Reform Act, Md. Ins. Code Ann. §§ 15-1201 *et seq.* (1997), the State has required that any group health insurance policy sold to a small employer or its benefit plan must provide a number of specific benefits. Md. Ins. Code. Ann. § 15-207 (1997); Code of Maryland Regulations (COMAR) 09.31.05.03.[1] State law does not require that any employer purchase such insurance, or that any self-funded plan provide benefits equivalent to those that must be provided by an insurer.

In 1993 and 1994 (coincident with implementation of the 1993 Act), petitioner received complaints concerning the marketing of "stop-loss" policies featuring specific attachment points as low as $500 or $1000 per participant per year. Pet. App. 41a. In his order adopting the regulation at issue in this case, petitioner noted that conventional stop-loss insurance "is intended to insure only against catastrophic or un-

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[1] The state insurance code was recodified effective October 1, 1997. The 1993 Act was previously codified at Md. Ann. Code art. 48A, §§ 698 *et seq.* (1994 & Supp. 1996).

expected losses of the policyholder/employer[,] who retains a majority of the risk of loss on himself." *Id.* at 39a. Petitioner observed, however, that a "stop-loss" policy with very low attachment points "does not insure only against catastrophic loss," but is instead "a substitut[e] for health insurance." *Id.* at 41a. In petitioner's view, insurance carriers who developed and marketed low-attachment-point "stop-loss" policies were engaged in the "subterfuge" of "categorizing an employer as self-insured, and thus exempt from the state's [mandated-benefit] laws [by reason of ERISA preemption]," while "in reality[] providing direct health insurance" that "shift[ed] the majority of the risk to the insurance carrier." *Id.* at 41a-42a. Insurers could thereby sell a product functionally equivalent to group health insurance, without providing to plan participants "the protections and benefits intended by the Maryland General Assembly" when it enacted mandated benefit legislation. *Id.* at 42a.

In light of these concerns, petitioner sought to develop a regulatory test that would "provide a reasonable basis for discriminating between health insurance and true stop loss insurance." Pet. App. 42a, 44a. After soliciting and considering public comments (see *id.* at 42a-55a), petitioner adopted Section 09.31.02 of the Code of Maryland Regulations (COMAR) (*reprinted at* Pet. App. 56a-59a) in order to "delineat[e] the difference between two types of insurance policies" by "defin[ing] the point below which the sale of 'stop loss' insurance is, in fact, [the sale of] health insurance with a deductible rather than catastrophic loss coverage." *Id.* at 50a; see also *id.* at 55a ("[t]he purpose of the regulation is to define what is true stop loss coverage"). The order dis-

claims any intention to "require an ERISA plan to provide mandated benefits, prohibit plan provisions, or force a certain benefit structure," or otherwise to "influence or regulate the underlying ERISA plan." *Id.* at 49a-50a (citations omitted).

As adopted, the regulation provides that "[a] policy or contract issued to an employer may be considered to be a policy or contract of stop-loss health insurance coverage only if" specified conditions are met. COMAR 09.31.03(B). The policy must be issued to and insure the plan (or its employer sponsor), rather than its participants or beneficiaries, and the insurer's liability on the policy must run only to the plan itself. COMAR 09.31.03(B)(1)-(2). In addition, the policy may not set a specific attachment point lower than $10,000 per participant per year, or an aggregate attachment point lower than 115% of expected total claims for the policy period. COMAR 09.31.03(B)(3)-(4). A policy that does not meet those requirements, but insures an employer against losses or claims related to employee health, "is considered to be a policy or contract of health insurance" (COMAR 09.31.02.03(A)), but it does not qualify as "stop-loss" insurance.

3. Respondents are three employer sponsors of ERISA plans, the insurance company from which they purchased a policy denominated as stop-loss insurance, and their plan administrator. Pet. App. 3a. In 1994, petitioner ordered the insurer and administrator to cease and desist from issuing or delivering unapproved insurance policies in Maryland, and to submit for approval, among other things, all policies and policy forms for stop-loss insurance issued to ERISA plans in Maryland. C.A. App. 52-57. Petitioner later informed the insurer that he would not

approve its forms without receiving written assurance that policies would not be written with attachment points less than specified minimums. Pet. App. 4a; C.A. App. 58; see Pet. App. 40a. If the insurer wished to issue a policy with lower attachment points, petitioner would "require that the contract satisfy all of Maryland's health insurance mandates." C.A. App. 58.

In this suit, respondents sought a declaratory judgment that ERISA preempts Maryland's effort to set minimum attachment points for "stop-loss" policies issued to ERISA plans.[2] Pet. App. 5a, 20a; C.A. App. 13-16. In granting summary judgment for respondents, the district court first concluded (Pet. App. 26a-28a) that the regulation "relate[s] to" ERISA plans within the meaning of ERISA's basic preemption provision, 29 U.S.C. 1144(a), because it "attempts to prevent small employers * * * from avoiding the minimum health insurance coverage required by Maryland law" by "forc[ing them] to either bear more risk by means of the adoption of a higher attachment point, or to abandon self-funding and purchase a health insurance policy which would include state-mandated coverage." Pet. App. 24a-25a.

The court further determined (Pet. App. 28a-33a) that ERISA's insurance saving clause did not apply, even though the Maryland regulation by its terms "directly regulates insurance" (Pet. App. 32a). Distinguishing between an "insured" plan, which "a

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[2] Respondents' suit challenged the policy reflected in the cease-and-desist letters issued by petitioner, which had not yet been codified in regulations. See Pet. App. 40a. Petitioner issued a proposed regulation in 1995. See *id.* at 44a & n.2. The parties and the courts below have treated the suit as challenging the present regulation. See *id.* at 4a-5a, 20a.

State may regulate * * * indirectly through regulation of its insurer and its insurer's insurance contracts," and an "uninsured" plan, which the State "may not regulate," the court concluded that "the purchase of stop-loss insurance does not strip * * * plans of their self-funded status," and that consequently "the self-funded plans at issue in this case [could not] be considered to be insured and [therefore] subject to indirect State regulation." *Id.* at 31a-32a. Accordingly, the court held that ERISA precludes the State from "regulat[ing] the self-funded and self-insured benefit plans at issue in this case by mandating minimum attachment points for stop-loss insurance." *Id.* at 33a, 36a-37a.[3]

4. The court of appeals affirmed. Pet. App. 1a-15a. Like the district court, the court of appeals first distinguished between insured plans, which "may be indirectly regulated through regulation of th[e] insurance," and self-funded or self-insured plans, which "may not themselves be regulated * * * even if the[y] * * * purchase[] stop-loss insurance to cover losses or benefits payments beyond a specified level." *Id.* at 6a-7a.[4] The court rejected any effort to "distinguish self-funded plans from insured plans

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[3] In a later exchange of letters with the parties, the court refused respondents' request to invalidate COMAR 09.31.02 in its entirety. See C.A. App. 117-129. The court expressly limited its judgment, enjoining enforcement of the regulation only to the extent that it mandated, regulated or affected "attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans covered by ERISA." Pet. App. 36a-37a; see C.A. App. 128-129.

[4] Petitioner conceded in the court of appeals that his regulation "relate[s] to" ERISA plans within the meaning of 29 U.S.C. 1144(a). See Pet. App. 9a-10a.

* * * based on the level of the attachment point of stop-loss insurance" (*id.* at 13a), because that would "blur[] the real distinction" between the two types of plans. *Id.* at 12a. In the court's view, that distinction was that a participant in an insured plan would have a claim for benefits directly against (and only against) the insurer, whereas a participant in a self-funded plan would have a claim only against the plan itself. *Id.* at 13a. Thus, "in a self-funded plan, with or without stop-loss insurance and regardless of the attachment point, the provision of benefits depends on the plan's solvency, whereas the provision of benefits in an insured plan depends entirely on the insurer's solvency." *Ibid.* The court accordingly considered this case on the premise that petitioner's regulation fixes minimum attachment points for "stop-loss" insurance policies issued to "self-funded" plans. *Id.* at 2a.

The court recognized that petitioner's regulation was "carefully drafted to focus directly on insurance companies issuing stop-loss insurance," and that at least "superficial[ly]" it "address[ed] the business of insurance." Pet. App. 11a. The court found the analysis "complicated," however, by its assessment that "the intended, stated, and actual effect of the regulations is to reach the relationship between ERISA plans and their participants who are not parties to the insurance contract." *Ibid.* In the court's view, petitioner had endeavored to "use stop-loss insurance policies as a vehicle to impose the requirements of Maryland health insurance law on self-funded ERISA plans," and in so doing had "crosse[d] the line of preemption" by "regulating self-funded employee benefit plans that are exclusively subject to ERISA." *Id.* at 11a-12a.

The court observed that petitioner was free to "regulate stop-loss insurance policies," because "[s]uch regulation is clearly reserved to the states." Pet. App. 15a. In this instance, however, the court concluded that the State's attempt to regulate would "directly and impermissibly affect ERISA plans' costs and choices in designing their own array of benefits," because if a self-funded plan bought stop-loss coverage with a low attachment point, "the regulation[] would either raise plan costs by including unwanted, state-mandated insurance coverage * * * or convert the self-funded plan into a fully insured plan contrary to its preference." *Id.* at 14a. Accordingly, the court held petitioner's regulation preempted, because its "purpose and effect * * * is to force state-mandated health benefits on self-funded ERISA plans when they purchase certain types of stop-loss insurance." *Id.* at 3a; see *id.* at 15a.

DISCUSSION

1. The court of appeals focused its analysis on whether the respondent plans were properly viewed as "self-funded," on the one hand, or "fully insured," on the other. See Pet. App. 12a-15a. That approach gives substantive weight to non-statutory terms that should be understood as only descriptive shorthand. ERISA's preemption and insurance saving provisions do not differentiate between benefit plans that purchase health insurance to cover their participants and those that pay covered health care expenses themselves. See 29 U.S.C. 1144(a), (b)(2). The proper statutory inquiry in this case is, instead, whether petitioner's regulation "regulates insurance" (without, for that purpose, "deem[ing]" any plan "to be an insurance company"). 29 U.S.C. 1144(b)(2).

This Court's decisions interpreting the interplay of the Act's preemption and insurance saving provisions (see 29 U.S.C. 1144(b)(2)(A) and (B)) have, to be sure, distinguished between what the Court has referred to as "insured" and "uninsured" (or "self-funded") plans. *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61, 64 (1990); *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 746-747 (1985). In *FMC*, for example, the Court summarized its discussion of the statutory framework by observing that "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it." 498 U.S. at 64. That statement may accurately capture the effect of the statutory scheme. As the Court's phrasing indicates, however, the functional distinction drawn by the Act is not between "insured" and "uninsured" plans, but rather between the regulation of benefit plans and the regulation of insurance.

A State does not acquire power to regulate a plan simply because the plan buys insurance. In buying the insurance, however, the plan must generally operate within whatever limitations or conditions a State otherwise validly imposes on the types or terms of policies that may be purchased within its jurisdiction. Thus, a State may never specify what health care benefits a plan must provide to its participants. If, however, the plan chooses to buy insurance to cover its potential liability for promised benefits, the policy options available to it in the marketplace may be validly limited by state insurance regulations—including, for example, rules that mandate the inclusion of particular benefits in any policy of health insurance. See generally *Metropolitan Life*, 471 U.S. at 739-747.

The regulation at issue in this case, as we understand it, prohibits the sale to employee benefit plans of "stop-loss" insurance that would begin covering a plan's liability for health care benefits at attachment points below state-specified minimums.[5] The court of appeals concluded that ERISA preempts the regulation because it believed that a plan that purchases insurance with benefits that run only to the plan (and not to its participants) is necessarily "self-funded," and because it regarded petitioner's regulation as an attempt to regulate such "self-funded" plans. Pet. App. 3a, 12a-14a.

It seems anomalous to characterize as "self-funded" a plan that seeks to purchase insurance to cover almost all of its potential benefits liability, and that complains only about the State's regulation of the availability or terms of such insurance. More to the

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[5] The stated premise of the regulation—that "stop-loss" insurance with sufficiently low attachment points is functionally indistinguishable from traditional group health insurance (see, *e.g.*, Pet. App. 41a)—is a reasonable one. For many purposes, such "stop-loss" coverage closely resembles group insurance subject to a deductible, allowing the plan to bear only known or highly predictable costs, while shifting most or all risk of large or unexpected claims to the insurer. Because most employers and plan participants would perceive little or no practical difference between a group health insurance contract with a given per-employee annual deductible and a "self-insurance" plan with the same specific attachment point (provided that the two plans cover the same substantive benefits and that both employer and insurer are solvent), there is considerable force to petitioner's concern that Maryland's mandated-benefits laws will be substantially undercut if employers, unlike other consumers, may avoid the effect of those laws merely by changing the caption of their policy contracts from "group health insurance" to "stop-loss insurance."

point, however, petitioner's regulation addresses only the substantive terms on which a particular type of insurance policy may be made available by insurance companies subject to his jurisdiction—a type of regulation that this Court approved in *Metropolitan Life*. See 471 U.S. at 741. If the respondent plans do not seek to purchase that type of insurance, then they are not affected by any state regulation. If they do wish to purchase such insurance, they may do so only on the terms on which the State allows insurers to make it available.

Thus, even if petitioner intended his regulation to affect the behavior of ERISA plans, he has pursued that goal only "indirectly through regulation of [a plan's] insurer and its insurer's insurance contracts"—an approach that ERISA specifically allows. *FMC*, 498 U.S. at 64; see also *Metropolitan Life*, 471 U.S. at 731, 741-744, 747; 29 U.S.C. 1144(b)(2)(A). So long as petitioner's regulation merely limits the terms on which a particular type of insurance may be made available, and so long as enforcement of the regulation is directed solely at insurance carriers (rather than at plans or their participants), we agree with petitioner that this case is governed by the principles of *Metropolitan Life*, and that the court of appeals erred in concluding otherwise.

2. The parties appear to agree that the decision below conflicts with that of the Sixth Circuit in *Michigan United Food & Commercial Workers Unions* v. *Baerwaldt*, 767 F.2d 308 (1985), cert. denied, 474 U.S. 1059 (1986). See Pet. 16; Resp. Br. 19-20 & n.15. We perceive no clear-cut conflict in the circuits on the question presented in this case, although we agree that the reasoning of the opinion below is in

considerable tension with views expressed by at least one other court of appeals.

In *Baerwaldt*, the Sixth Circuit held that a state law mandating the inclusion of certain benefits in "all health insurance policies" could be validly applied, under *Metropolitan Life*, to "group insurance policies" purchased by two benefit plans. See 767 F.2d at 309-310 & n.1. As the court described those policies, the plans paid for all benefits "provided under the group policies up to an agreed upon amount," after which the insurer was "liable for payment of additional benefits under the applicable policies." *Id.* at 310. The opinion summarizes this arrangement by characterizing the plans as "self insured up to the claims liability limit" (*ibid.*) and the insurance as "stop loss [in] nature" (*id.* at 312).

It is at best unclear whether the contractual arrangement in *Baerwaldt* was the same as that at issue here. Nothing in the opinion specifies, for example, whether the insurer's legal duty to "pay all benefits in excess" of agreed limits (767 F.2d at 313) was owed only to the plan, or directly to plan participants. Moreover, the court's holding rests on its conclusion (*id.* at 312) that the facts before it framed "precisely" the same issue resolved by this Court in *Metropolitan Life*. It is therefore not clear either that the Fourth Circuit would have found the plans involved in *Baerwaldt* to be "self-funded" (compare Pet. App. 7a-8a, 12a-14a), or that the Sixth Circuit would consider *Baerwaldt* controlling on the facts of this case.

As petitioner points out (Pet. 16-17), the Sixth Circuit relied in part on *Baerwaldt* in deciding *Northern Group Services, Inc.* v. *Auto Owners Insurance Co.*, 833 F.2d 85, 91, 95 (1987), cert. denied, 486 U.S. 1017

(1988). Although the matter is not clear, it appears that the insurance at issue in that case may have involved a different sort of "stop-loss" arrangement. *Id.* at 91; see *Northern Group Servs., Inc.* v. *State Farm Mutual Auto. Ins. Co.*, 644 F. Supp. 535, 538 (E.D. Mich. 1986) (insurance was "obtained to insure the Plan against the employer's failure or inability to make contributions to the Trust Fund"). Moreover, the question whether one of the plans involved was "insured" was not a primary focus of the *Northern Group* opinion; and the case's primary holding—that a state coordination-of-benefits provision could be applied directly to plans that bought no insurance at all—has been superseded by this Court's decision in *FMC*. Indeed, since *FMC* the Sixth Circuit has held that application of a provision similar to that at issue in *Northern Group* was preempted, even as to a plan that purchased what appears to have been conventional "stop-loss" insurance. See *Lincoln Mut. Casualty Co.* v. *Lectron Prods., Inc.*, 970 F.2d 206, 210 & n.3 (1992). We are therefore reluctant to place great weight, for present purposes, on *Northern Group*'s passing reference to *Baerwaldt*.

There is some tension between the decision below and considered dicta in the Fifth Circuit's decision in *Brown* v. *Granatelli*, 897 F.2d 1351, cert. denied, 498 U.S. 848 (1990). *Brown* held that a Texas mandated-benefits law did not, as a matter of state law, apply to the particular stop-loss health benefits policy at issue in that case—thus avoiding any ERISA preemption issue. *Id.* at 1354; see *id.* at 1355 (Reavley, J., concurring). The court emphasized, however, that its state-law holding should not be extended to other facts in a way that would "frustrate an otherwise manifest [state] legislative purpose":

> We do not suggest that [the mandated benefits law] can be avoided by naming an employee benefit plan as the insured on a policy which in reality insures the plan participants. If, for example, a plan paid only the first $500 of a beneficia[ry's] health claim, leaving all else to the insurer, labeling its coverage stop-loss or catastrophic coverage would not mask the reality that it is close to a simple purchase of group accident and sickness coverage. We look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier to see whether the plan is in fact purchasing insurance for itself and not for the plan participants, recognizing that as insurance is less for catastrophic loss, it is increasingly like accident and sickness insurance for plan participants. * * * In short, if the Plan were merely a conduit for claims from participants to [the insurer] we could not reach the same conclusion.

Id. at 1355; see also *id.* at 1356 (Brown, J., dissenting).

These observations bear a striking resemblance to petitioner's stated rationale for adopting the state regulation at issue in this case. Compare Pet. App. 40a-47a, 50a; see note 5, *supra*. While not essential to the court's decision in *Brown*, they were plainly included in its opinion in order to clarify and confine the holding of the case. See 897 F.2d at 1354 (holding subject to an "important qualification"). And, while the court did not reach the issue of ERISA preemption, the thrust of the opinion suggests that if the panel had felt it appropriate to recharacterize a nominal "stop-loss" policy as "group accident and

sickness coverage" for purposes of state law, it would have been inclined to view that law as regulating "insurance" and therefore as saved from preemption. See also *id.* at 1358 (Brown, J., dissenting) (plan participants should be able to enforce state benefit mandates directly against a stop-loss carrier no matter what the policy's attachment point).

One might therefore infer that the Fifth Circuit would likely uphold, against an ERISA preemption challenge, a state regulation that sought, as a matter of state insurance law, to "define[] the point below which the sale of 'stop-loss' insurance is, in fact, health insurance with a deductible rather than catastrophic loss coverage." Pet. App. 50a. On the other hand, one might also infer that it would likely sustain an ERISA preemption challenge if it thought that state regulators had purposely set the attachment point too high in an attempt to impose mandated benefits on self-funded plans. The fact remains, therefore, that neither the Fifth Circuit nor any other federal court of appeals has, to our knowledge, squarely addressed a situation directly comparable to that at issue here and resolved an actual case in a manner that conflicts with the decision below.[6]

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[6] Petitioner suggests (Pet. 18) a conflict with *United Food & Commercial Workers* v. *Pacyga*, 801 F.2d 1157, 1161 (9th Cir. 1986), and *Moore* v. *Provident Life & Accident Insurance Co.*, 786 F.2d 922, 927 (9th Cir. 1986), but those cases hold only that an ERISA plan does not, by virtue of purchasing stop-loss insurance, become subject to state anti-subrogation rules or to state causes of action that would lie against an insurer—an issue quite different from whether a State may reasonably define when a policy denominated "stop-loss" insurance will be treated as a group health insurance policy for state regulatory purposes. Nor does the decision below conflict with *Safeco Life*

3. The parties to this case, joined by 22 States, the District of Columbia, and the National Association of Insurance Commissioners, contend that the question presented here is one of current importance and wide application that should be resolved promptly. We have no reason to dispute that contention. Two factors, however, give us pause in suggesting that this case meets the Court's usual prudential standards for granting discretionary review. The first is the absence, as just discussed, of any actual conflict among the lower courts on the precise question presented. The second is a possible ambiguity in the Fourth Circuit's treatment of the particular state regulation at issue in this case.

We have discussed this case on the premise that petitioner's regulation simply prohibits the sale to employee benefit plans of "stop-loss" coverage that attaches at per-person or overall liability limits lower than state-specified minimums—with the consequence that employers or plans that do not wish to assume the specified level of potential direct liability have only one insurance option, which is the purchase of conventional group health insurance that is subject to state mandatory benefit laws. See page 11, *supra*. We understand that to be petitioner's interpretation of his own rule (see Pet. 4-5, 14-15; Pet. C.A. Br. 12-13, 20-25; Pet. C.A. Rep. Br. 6, 8-9); nothing in respondents' brief in this Court is inconsistent with that

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Insurance Co. v. *Musser*, 65 F.3d 647, 651 (7th Cir. 1995) (fee imposed on all health insurers in a State does not "relate to" ERISA plans), or with *Gonzales* v. *Prudential Insurance Co.*, 901 F.2d 446, 452-454 (5th Cir. 1990) (state disability insurance laws may not be applied directly to an ERISA plan). See Minnesota *et al.* Amicus Br. 11; Nat'l Ass'n of Ins. Comm'rs Amicus Br. 14-15.

position (see Resp. Br. 1, 8-10, 16); and the district court's judgment, which the court of appeals affirmed without modification (Pet. App. 15a), was limited to the preemption of "any regulation * * * that mandates or affects attachment points for stop-loss insurance policies purchased by self-funded or self-insured employee benefit plans" (*id.* at 36a; see note 3, *supra*).[7] The Court could appropriately accept and decide the case on the same assumption. Cf. *Auer* v. *Robbins*, 117 S. Ct. 905, 911 (1997) (agency's interpretation of its own regulations is normally "controlling").

We note, however, that respondents' brief in the court of appeals at times suggested that petitioner's regulation goes further, by "recharacterizing stop-loss reinsurance as health insurance" in a way that "fundamentally alter[s] the benefit structure established by any plan that runs afoul of [the regulation's] provisions" and "*creat[ing]* a relationship between the stop-loss reinsurer and the beneficiaries of the plan." Resp. C.A. Br. 34; see also *id.* at 38-40 (discussing other provisions of the regulation, and arguing that the district court erred in not declaring them preempted). More important, it is difficult to tell from the opinion below whether the court of appeals read the regulation simply to prohibit sales of stop-loss insurance with attachment points below the mandatory minimums (so that only group health insurance, subject to the State's mandatory benefit provisions, may be made available for purchase), or

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[7] The only enforcement action that petitioner took in this case was to disapprove respondents' purported stop-loss policies and order that they not be sold in Maryland. C.A. App. 52-59; Pet. 15; Pet. App. 4a.

whether it believed that the regulation would have the effect of recharacterizing existing policies with low attachment points as health insurance policies (thereby creating liability for additional benefits on the part of a plan or its insurer by operation of law). See Pet. App. 3a, 5a, 9a, 14a-15a.

While we understand petitioner to disavow any intention to convert policies issued as "stop-loss" coverage into group health policies by operation of state law, and although petitioner's permissible interpretation of his own regulation should be dispositive on that point, the regulation's text could, on its face, support either construction. See COMAR 09.31.02.03(A) and (B) (defining any policy that insures against employee health-related "losses or claims" as "health insurance" and establishing requirements for "stop-loss health insurance coverage," but not defining the consequences of either designation). A state regulation that purported to rearrange existing contractual relationships among plans, their participants, and plan insurers, even as a remedy for violation of an otherwise valid insurance regulation, would raise concerns substantially different from those discussed above, and might well be preempted by ERISA. The operative interpretation of state law could therefore be of critical importance in resolving this case.[8] The state-law question is not,

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[8] The Stop Loss Insurance Model Act promulgated by the National Association of Insurance Commissioners is substantially clearer in this regard than petitioner's regulation. See 1 NAIC, *Model Laws, Regulations and Guidelines* 92-1 (1995). It appears that a number of other States have also taken some legislative or regulatory action on the "stop-loss" issue. See, *e.g.*, Or. Rev. Stat. § 742.065 (1995); Colo. Rev. Stat. Ann. § 10-16-119 (West 1998); N.J. Stat. Ann. § 17B:27A-17 (West 1996 & Supp.

however, well developed on the present record, and at any rate it would not in itself warrant review by this Court.

Although the question is a close one, on balance we believe that the potential ambiguity in applicable state law and the absence of a square conflict in the circuits counsel against the use of this case as a vehicle for review of the question presented.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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1997) (*s.v.* "stop loss"); N.Y. Ins. Law § 4317(e) (McKinney Supp. 1998).